

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

04 - 002

2. STATE

INDIANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

3/15/04

TO: REGIONAL ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION

42 CFR 447.50

7. FEDERAL BUDGET IMPACT

a. FFY 2004 \$ 0

b. FFY 2005 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.18-A, page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)

Attachment 4.18-A, page 1

10. SUBJECT OF AMENDMENT

restore pharmacy copayment language from previous Plan until 5/1/04

11. GOVERNOR'S REVIEW (Check One)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ OTHER, AS SPECIFIED

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL

Melanie Bella

13. TYPED NAME

MELANIE BELLA

14. TITLE

ASST. SECRETARY, OMPP

15. DATE SUBMITTED

2/26/04

16. RETURN TO

Melanie Bella, Asst. Secretary

OMPP

402 W. Washington, Rm W382

Indpls. IN 46204

ATTN: T. BRUNNER, PLAN COORD.

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

3/10/04

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

3/15/04

20. SIGNATURE OF REGIONAL OFFICIAL

REC'D

21. TYPED NAME

22. TITLE

MAR 03 2004

Acting Associate Regional Administrator

DMCH - AREA

23. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Indiana

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge		Amount and Basis for Determination
	Deduct.	Copay	
Transportation		X	\$0.50 for transportation services for which Medicaid pays \$10.00 or less
			\$1.00 for transportation services for which Medicaid pays \$10.01 to \$50.00
			\$2.00 for transportation services for which Medicaid pays \$50.01 or more
Pharmacy		X	Fifty cents (\$0.50) for each generic legend drug dispensed
			Three dollars (\$3.00) for each brand name legend drug dispensed
			Fifty cents (\$0.50) for each nonlegend drug dispensed, whether brand name or generic
			Fifty cents (\$0.50) for each compounded prescription dispensed, whether legend or nonlegend
Emergency Room		X	\$3.00 for nonemergency services (procedures billed outside a designated emergency procedure code range) when provided in a hospital emergency room

TN No. 04-002

Supersedes

TN No. 04-001

Approval Date MAR 10 2004

Effective Date March 15, 2004